STATE OF CONNECTICUT
State Innovation Model
Quality Council

Meeting Summary
Wednesday, October 29, 2014

Members Present: Gregory Barbiero; Rohit Bhalla; Aileen Broderick; Mehul Dalal; Deb Dauser Forrest; Daniela Giordano; Karin Haberlin; Gigi Hunt; Elizabeth Krause; Steve Levine; Arlene Murphy; Robert Nardino; Donna O'Shea; Meryl Price; Jean Rexford; Andrew Selinger; Todd Varricchio; Steve Wolfson; Thomas Woodruff

Members Absent: Mark DeFrancesco; Kathleen Harding; Kathy Lavorgna; Rebecca Santiago

Meeting was called to order at 6:05 p.m.

1. Call to order

Steve Wolfson served as meeting chair. Mark Schaefer introduced Monica Farina, a volunteer who will be assisting with the Quality Council, and Kevin Morris, an intern with the SIM program management office.

2. Public Comment

There was no public comment.

3. Minutes

Motion: to approve the minutes of the October 8th meeting – Andrew Selinger; seconded by Donna O'Shea.
Discussion: There was discussion of using the core measurement set to examine the performance of individual physicians. Dr. Wolfson expressed concern that the discussion went beyond the approval of the minutes. Dr. Schaefer said the payers may be able to educate the rest of the group on this issue and suggested they provide a presentation at a future meeting.
Vote: all in favor.

The Council tabled voting on the September 23rd minutes to the next meeting.

4. Updates

Dr. Schaefer provided an update on design group activities. Robert Zavoski is convening a pediatric design group with the Connecticut Academy of Pediatrics. The Care Experience group has met once and is in the process of examining consumer assessment of healthcare providers. The group will be present an overview of the Medicare ACO CAHPS (Consumer Assessment of Healthcare Providers and Systems). The group is conferring with Dr. Paul Cleary of Yale. Dr. Cleary was part of one of the research teams that designed the CAHPS. Their deliberations do not need to be limited to CAHPS. The Behavioral Health group has scheduled its first meeting for October 31. They are interested in bringing a psychiatrist on board. There have also been discussions of working with the Practice Transformation Taskforce, with the proposal to create a joint design group that would include Karin Haberlin, Daniela Giordano, Heather Gates, and Victoria Veltri. This group will work to find solutions for behavioral health integration and corresponding measures.

The Council on Medical Assistance Program Oversight's (MAPOC) Care Management Committee is working on Medicaid quality measures. They are not optimistic they can meet the December 10th deadline. There would need to be at least one meeting after that date to look at the Medicaid measures so that they would have a truly multi-payer scorecard.

Elizabeth Krause provided an update on the Health Equity group. Their group includes Aileen Broderick, Kathy Lavorgna, Theanvy Kuoch (from the Consumer Advisory Board), Wayne Rollins (from Aetna), Dora Hughes (from Sidley Austin); and Ignatius Bau (a health policy consultant). They have had one conference call to date where they worked to understand their charge.

Arlene Murphy asked who was working with Kate McEvoy on the Medicaid measures group and how the process would work. She asked if their feedback would be received before or after the Quality Council made its decisions. Dr. Wolfson said it would need to be before. The goal is for each of the workgroups to make their recommendations before they go to the Healthcare Innovation Steering Committee. Dr. Schaefer said Medicaid's task is more complicated than the design groups as they determine what is missing. He proposed that they supplement their measurement set with Medicaid's priority items. He noted that none of the decisions are binding but the goal is create consensus and encourage buy in. Ms. Murphy said it would be helpful to know who is participating in the Medicaid measure review process and find ways to communicate with them. Dr. Wolfson suggested the executive team handle this.

5. CT population health and disease burden

Mehul Dalal presented population health and health disparities data (see presentation here). Todd Varricchio asked about the slide showing potential years of life lost (slide 7) and whether the bar would change if they looked at measures in terms of behavioral health. Dr. Dalal said the slide is based on what is listed on the death certificate is primary cause of death. There is behavioral health data available and it could have been listed as a co-diagnosis. Ms. Giordano cited studies that show those with mental health issues have a 25-year shorter life expectancy. The group discussed the impact behavioral health had on overall health. Dr. Dalal said he can talk to the epidemiologists at the Department of Public Health to look at mental illness as a co-diagnosis but he noted that information on those with multiple co-morbidities may be a challenge. Rohit Bhalla suggested looking at the National Health and Nutrition Examination Survey for data on diabetes and screening interventions. Dr. Dalal said he made a note to look at measures where there is state specific data, however, the NHANES does not have Connecticut specific data.

6. Payers – priority conditions for commercial populations

Todd Varricchio, Aileen Broderick, and Deb Dauser Forrest provided an overview of their priority health conditions (see Dr. Dauser Forrest's presentation here). There was a great deal of overlap between the three payers with diabetes, cardiac conditions, respiratory conditions, cancer, and avoidable emergency room utilization common among them. They also noted high prevalence of depression and other behavioral health issues. Ms. Broderick looked at the top ICD-9 codes from calendar year 2013. In addition to the conditions noted above, osteoarthrosis and other back and joint issues also came up as common. Dr. Wolfson said that was surprising. Ms. Broderick said it was among the top claims but that Anthem would not necessarily focus on it as a priority.

Mr. Varricchio said they try to pass the information on to providers so they can make connections. Aetna looks for incremental improvement as they take into account that some providers may have a longer path to travel. If they reach a reasonable threshold they will stop asking for continued cost reductions. Steve Levine asked about acute care monitoring. Mr. Varricchio said they have pay for performance arrangements with the hospitals based on claims and they have discussions on clinical appropriateness.

Ms. Broderick noted that septicemia was the number 2 reason for readmission under Medicare. Donna O'Shea said that will frequently come up as it is a common reason for readmission. Mr. Varricchio said Aetna excludes mental health and pregnancy from their readmission data as neither is easily controllable.

Ms. Murphy asked how they were determining new episodes of depression. Ms. Broderick said it came from pharmacy based claims data. The group discussed the common theme of behavioral health. Dr. O'Shea said depression is mainly diagnosed through primary care but that it is under diagnosed and under treated. Reimbursement rates are typically low for mental health and many mental health care providers do not accept insurance. Ms. Giordano said that there are three mental healthcare systems: one for those eligible for Medicaid, the general commercial market which may have difficulty achieving access to care, and those with enough income to pay out of pocket. She said the systems do not talk to one another.

Dr. Schaefer asked the payer representatives to create a one or two page summary to be shared as a reference with the rest of the Council.

7. Three level review method

Dr. Dalal provided an overview of the proposed process to review quality measures (see proposed process here). He said they could potential wind up with too many measures but that the exercise could also identify gaps. It was asked what measures would be reviewed. Dr. Wolfson said it would include Medicare and commercial payer measures as well as those proposed by the design groups (pediatric, care experience, behavioral health, Medicaid, health equity). Mr. Varricchio described the proposal as an ideation process where Level 1 is the wish list and Level 2 brings things into focus. He said they would not get to Level 3 until they had completed Level 1 and 2.

Motion: to approve the three-level review process proposal with revisions – Jean Rexford; seconded by Andrew Selinger.
Jean Rexford asked whether they should be checking for conflicts with their guiding principles. Both Mr. Varricchio and Dr. Dalal said they should be used throughout the process. Level 3 would serve as a final check. Dr. Schaefer suggested referencing the guiding principles in the introduction. Dr. Wolfson suggested eliminating the examples in parentheses in the first bullet under Level 2. Dr. Schaefer suggested looking at the intent of the measure developer. If it was not designed to match their efforts, they would not likely include it. Ms. Murphy said that they could preliminarily approve Levels 2 and 3 pending the outcome of Level 1. There was concern about the action in each bullet. It was suggested measures would be accepted based on the consensus of the group.
Vote: all in favor.

8. Selection of core measures – three level review and continued review of performance measure summary table
This was not discussed due to a lack of time.

9. Measuring care experience
This was tabled to the next meeting due to a lack of time.

Dr. Wolfson said they will try to schedule an additional meeting between November 19 and December 10. Dates will be circulated. Dr. Schaefer said he would share the comments and responses on Medicare's initial proposal of 65 ACO measures to help understand why Medicare felt they were important. He said the PMO would try to forward information on the choice of the 37 ACO measures but that information is limited.

10. Adjourn
Meeting adjourned at 8:07 p.m.